AGREEMENT TO COMPENSATION OF EMPLOYEE AND EMPLOYER

State Form 1043 (R2 / 5-96)

Indiana Worker's Compensation Board 402 West Washington Street, Room W196 Indianapolis, Indiana 46204	File number

PRIVACY NOTICE: This agency is requesting disclosure of employee's Social Security number in accordance with IC 22-3-4-13.

Please check appropriate box

☐ Temporary Total Disability (TTD) ☐ Permanent Partial Impairment (PPI)

☐ Temporary Partial Disability (TPD) ☐ Permanent Total Disability (PTD)

Employer's Federal I.D. number	Name of employer	Telephone number ( )
Address *(street, number, city, state and ZIP code)*		

Employee's Social Security number	Name of employee	Telephone number ( )
Address *(street, number, city, state and ZIP code)*		

We *(employee and employer)* have reached an agreement in regards to compensation for the injury sustained by said employee and submit the following statement of facts relative thereto.

Date of injury / illness / exposure	Nature of injury / illness / exposure
Date disability began	

Place of injury / illness / exposure

Cause of injury / illness / exposure

Probable length of disability

The terms of this agreement under the above facts are as follows:

That _____ shall receive compensation at the rate of $ _____

per week based upon an average weekly wage of $ _____ and that said compensation shall be

payable *(i.e., weekly or bi-weekly)* _____ until terminated in accordance with the provisions of the Indiana Worker's

Compensation / Occupational Diseaese Acts.

If PPI settlement, please provide impairment rating, number of weeks and amount to be paid

SIGNATURES

Signature of employee

Signature of employer

Name of insurance carrier	Telephone number ( )	(FOR BOARD USE ONLY)
Address *(street and number)*		
City, state and ZIP code		
Authorized signature and title		
Date of agreement		